Universalising Health Care for All

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Oppose Corporate Health Care
Strengthening the Public Health System

Jan Swasthya Abhiyan

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Community Health
Library and Information Centre (CLIC)
Community Health Cell
85/2, 1st Main, Maruthi Nagar,
Madiwala, Bengaluru - 560 068.
Tel : 080 - 25531518
email : clic@sochara.org / chc@sochara.org
www.sochara.org

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November, 2012

Published by Amit Sengupta, on behalf of Jan Swasthya Abhiyan, and
Printed at Progressive Printers, 21 Jhilmil Industrial Area, G.T. Road
Shahdara, Delhi-110095

Contributory Price: Rs.20.00

Jan Swasthya Abhiyan
National Secretariat:
email: jsasect.delhi@gmail.com

Sama - Resource Group for Women and Health
B-45 2nd Floor, Main Road Shivalik, Malviya Nagar,, New Delhi-110017
Phone : 011-65637632/26692730

Delhi Science Forum
D-158, LGF, Saket, New Delhi - 110 017
Phones: 011-26524323/ 26524324

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Introduction

In this booklet we present a brief analysis of certain key sectors and themes related to the Health system in India today. This is not an exhaustive description of all aspects of the Health system, but rather focuses on certain key areas which are the subject of debate in the country. The issues presented in the booklet are inter-related, and integrating the analysis presented would help us to develop our vision for transforming the health system in India.

This booklet may be viewed as a cross-cutting analysis. The transformation of the Health system needs to be carried out in a manner that prioritises the needs of sections with special health needs and populations which are vulnerable or marginalised in various ways. We know well that women, children and elderly people suffer disproportionately from denial of health rights due to combination of special health needs and negative influence of social hierarchies and power relationships. Persons living with HIV/AIDS and people with mental health problems today suffer serious discrimination, which compounds their health problems and leads to their health rights being violated in various ways. Dalit and Adivasi communities have historically suffered from major social exclusion which reflects in continued denial of their health rights. Migrants, unorganised sector workers, people living in situations of displacement and conflict, persons of different sexual orientation are often placed in situations of extreme marginalisation and require special measures to ensure protection of their health rights.

Our movements and programmes for Health system change would place these populations at the centre, as they are simultaneously oppressed by the present system, and are major protagonists in the process of changing this system.

Public Health Systems -- What do we want?

Both national and international experience teaches us that public health services will have to be the backbone of any system that guarantees access to quality health care services to all citizens of the country. But, for this to happen, public health services need to be expanded and strengthened to ensure that it becomes the principal provider of health care services the country. At the same time public services have to be accountable to communities and people they serve.

Before we proceed to elaborate on what we want from the public health system, it needs to be emphasized that health care is only one determinant of health outcomes. Good health is also a result of better nutrition, safe drinking water and sanitation, universal access to education, gainful employment and equitable and inclusive development, better working and living conditions, control over addictions as well as environmental pollution (both material and cultural) and an end to various forms of discrimination. Reduction in poverty itself contributes immensely to improved health outcomes. Changes in conditions that contribute to good health require the action of many sectors – the health sector is only one of these. The health department must become an active player in all policy decisions that have an impact on health. If development is to be inclusive, equitable and especially sensitive to the needs of the most marginalised, all programmes must have a health impact assessment - and every major policy initiative should be viewed through a health lens.

The presence of a strong and reliable public health system also serves to put a check on the unregulated growth of the private sector and helps in preventing unethical practices in the private sector. In the absence of a properly functioning public health system, efforts at regulation of the private sector – both for costs and quality — are likely to be much less successful as people would continue to be driven to the private sector in the absence of public alternatives.

Most importantly, provision of health care by the public sector allows citizens to hold the Government accountable and to meaningfully demand for health as a fundamental right.

We are all aware of the problems associated with the existing public health services in India – a limited range of services,

poor access and poor quality and management of services, influence of powerful vested interests (international and national) and bureaucracy driven reforms that do not allow for meaningful popular participation. Often due to unfilled vacancies or absenteeism or lack of medicines and equipment, even the services that are supposedly assured are not in practice available. Funds meant to strengthen the public health system do not get spent, or worse leak out as corruption. Public providers who have private practices, undermine the public system for personal profit. Given these persistent problems a situation has been created where people are made to believe that the public health system is doomed to fail. By an extension it is argued that the only remedy is to hand over health care to private providers and especially to the large corporatised private sector. Such arguments do not take into account the fact that the success stories of health systems are all stories of success of the public health system – in Cuba, Thailand, Costa Rica, Sri Lanka, Brazil, as well as in a number of developed countries.. The supporters of privatisation base their positions not on facts but on an ideological logic that public services are inherently inefficient. This is a position that sections in the present government would like to press for.

The Jan Swasthya Abhiyan's position, to the contrary, is that corporatization and privatization is a remedy worse than the disease. What is really needed is to pursue the goal of constructing an effective, efficient and accountable public health system. It needs to be remembered that in spite of the huge expansion of the private sector and grossly inadequate reach of public health services, an estimated 40-50% still rely on the public sector for in-patient care. We identify below a few key constraints facing public health systems and suggest alternatives through which the public health systems could be reformed and strengthened.

Access to Health Care Facilities

The broad picture that we see is a serious shortfall of facilities at all levels – from primary health centres to big hospitals (see Tables 1 and 2). The shortfall is often due to lack of facilities themselves, or a result of these facilities being unable to function because of lack of doctors and health workers and inadequate supplies of medicines and other consumables. The situation is made worse as a result of mismatch between demand

and supply — some facilities are very crowded while others are under utilized. Similarly human resources, equipment and funds do not match requirements. Often the content of services does not match the needs that people have. Thus in many facilities only immunization and some minimal care in pregnancy may be available, though the most common health problem may be injuries and fevers.

The challenge is to make District Plans that are responsive to the needs of the community as articulated by them in participatory processes and as measured by technical estimates of disease burden and costs of health care and as reflected in current patterns on utilization of services.

Another limitation that governments need to overcome is the institutional capacity to make and implement such plans. Yet another related challenge is building the skills and the systems needed to measure health outcomes and health processes in a decentralized manner, identify communities and areas where access is iniquitous and take affirmative action including additional resource allocation to reduce inequity. Identification of health care priorities and outcomes, requires consultations with the community, as well as robust epidemiological information.

Human Resources for Health

One of the most important deficiencies in the public health system -- indeed often the main limiting factor -- is the lack of skilled human resources, especially in rural and remote areas.

There are several important reasons for this crisis. Firstly the **deliberate choice made to halt government investment in public sector medical colleges and encourage private medical and nursing institutions.** This shift has further skewed the

Table 1: Status of Health Infrastructure in India

Infrastructure	March 2007	March 2011	Percent Increase	Required	Percent Gap
Sub-Centre	145272	148124	2	178267	17
PHC	22370	23887	6	29213	18
CHC	4045	4809	16	7294	34
Dt . Hospital	340	613	45	640	4

Source: *RHS Bulletin 2007 and 2011, MOHFW*

Table 2: Human Resources in Public Facilities					
Cadre	March 2007	March 2011	Percent Increase	Required	Percent Gap
ANM	147439	187675	21	393041	52
HW (Male)	62881	52215	-20	207480	75
Nurses	29776	65344	54	138623	53
Doctors	22608	26329	14	109484	76
Specialists	5117	6935	26	58352	88
Pharmacists	17919	24671	27	58389	58
Lab. Tech.	12101	16208	25	80308	80
Source: *RHS Bulletin 2007 and 2011, MOHFW*					

tendency of medical and nursing graduates to avoid serving in rural and remote areas. The first corrective needed is therefore for public investment in building medical, nursing and paramedical educational institutions that are primarily located in regions where the human resource gaps are worst.

The second corrective is to clearly identify skill requirements at different levels of care and to deploy health personnel based on such requirements. For example, a primary health care doctor, nurse or para-medic should have skills which are more comprehensive and appropriate to the needs. Specialist skills needed at a secondary hospital -- a CHC for example — are very different from what is needed in a medical college or tertiary care hospitals. Effecting such a change, requires alterations in existing curriculum, requires bridge courses and specially designed supplementary packages and even requires the creation of new professional categories.

Another important reason for the huge deficit in Public Health services is the complete lack of regulation of the private sector and promotion of the corporate sector. Doctors graduating from the burgeoning, hugely costly private medical colleges need to amass money by any means; something which has been made possible by complete lack of regulation of the burgeoning private sector. Most doctors look for lucrative opportunities in this unregulated market rather than consider a career in Public Health Services. Effectively regulation would make it less lucrative for medical professionals to gravitate towards the private sector.

Both of these measures while necessary are not sufficient. National and international experience teaches us what more

needs to be done. First and foremost is preferential selection for education and training from areas and communities which are under-serviced, and then training them as close to their areas as possible, in the state language preferably and deploying them back in these same districts. This should be supplemented with a package of financial and non-financial incentives and the building of a positive workforce environment that would retain the employees. It is not enough to berate doctors by saying that they are unwilling to serve in rural areas. Conditions of work need to be vastly improved to retain them in such areas. Minimum working conditions in terms of salaries, housing, rotational postings and secure conditions of employment are all necessary incentives.

Quality of Care

Government is now talking of providing universal access to health care. This should clearly mean universal access to ***quality*** health care, which in this context means not only achieving the desired clinical outcomes, but also assuring the users' safety, comfort and satisfaction.

The 12th Five Year Plan claims that " *a pure public sector delivery system involves funding a large public sector health system, with little incentive for the service providers to deliver a quality product*". **What is implied is that a public health system has no incentive to perform well unless it is forced to compete with the private sector.** This is a bogus argument, and is readily disproved if one looks at functioning public health systems in many parts of the world. The basic issue is that patients never have enough information in order to make an informed decision. So the path to reforming health services does not lie in making more choice available in the form of a competing private sector. There is a huge body of evidence – anecdotal and scientifically recorded – that shows how private providers entice patients with false claims and promises, fleece poor patients, and provide poor care. In practice, in the public sector, there are fewer commercial pressures that lead to irrational use of drugs and diagnostics and surgical procedures.

At the same time, in practice, the experience that patients have with the public health system is dismal. A major reason for this is because public care is seen as the last resort for those who cannot afford to go to the private sector. Access to quality care in the public system is not seen as a right, but as merely a

safety net for those who cannot afford 'better' care. This is not the logic around which a public health system is built. Quality health care, available through public facilities, should be the norm and not the exception. Unfortunately, an entirely erroneous understanding has been promoted that if people want quality care they should go to a private facility. The introduction of user fees in public facilities in the last two decades, further pushed away middle class sections, reinforcing free care as care for the BPL!

The National Rural Health Mission (NRHM), launched in 2005, marked an attempt to remedy the situation as regards quality of care in public facilities. The situation has started to change in some public facilities, though the changes have been inadequate and uneven. What is however significant is that we now have fresh evidence in India that good quality care, as certified by external assessors, can be provided by public hospitals. The failure in the Planning Commission's reports to note this advance is an ideological position against public services.

Quality Assurance Systems need to cover all public facilities to ensure optimal use of resources and for ensuring that the health outcomes are achieved. The core of all quality management systems is to define the outcomes and requirements of quality in terms of a set of standards, and then map the processes within the facility to identify the reasons for gaps in quality. Then different players are provided with training and sensitization inputs, management is strengthened and where needed work-flows are reordered so that these gaps are closed. Invariably some gaps require more investments but usually about 70% of the gaps in quality of care can be closed with existing resources.

Most important by making quality of health care measurable and comparable, it is possible to counter the most common argument advanced against a public health care system viz. that it cannot assure quality of care.

Quality of care is also dependent on the infrastructure, equipment and supplies being available. The critical gap is not just in resources -- it also lies in the lack of transparent and efficient systems by which these can be assured. Evidence from the work done by the Tamilnadu Medical Services Corporation (TNMSC) shows us how a public system can conduct procurements with the highest standards of transparency, quality and efficiency, and with equal efficiency allocate resources across facilities,

responsive to peoples needs. The TNMSC system can allow for reservation for the small scale sector and for the public sector in drug procurement. It is unfortunate that there has been limited uptake of the TNMSC model in other states of the country.

Affordability and Social Protection

Care provided in the public health care facility must be seen as a social protection measure, where the payment has been collected as part of general taxation and free service is provided by public health facilities. Where public health care facilities are unable to provide some service, these could be contracted in, but the endeavor should be that over 80% of all in-patient and out patient care needs are part of assured services available within a publicly provisioned district health system.

While it is true that even before the advent of neoliberal reforms resource allocation for building public health infrastructure was grossly inadequate, there was an implied understanding that public health services must progressively cover the entire population and should be free. Even as late as in 2002 the National Health Policy stated: "*The approach would be to increase access to the decentralized public health system by establishing new infrastructure in deficient areas, and by upgrading the infrastructure in the existing institutions*". **The introduction of user fees as part of the neoliberal reforms in the early 1990s was one of the factors that started changing the mind-set. Since hospitals were asked to recover costs of services, the corollary was to stop the supply of free medicines and diagnostics.** Only Tamilnadu resisted this ideology and hence became the model public health system that it is today.

A start towards free services has been made with the JSSK programme where pregnant women and newborn are to get free and comprehensive services. We are nowhere near achieving the desired goal of comprehensive and free services available through the public sector. But, even the limited experience under JSSK allows us to identify the bottlenecks, which include:

- The notion that 'free services are not valued' has become an internalized perception- and there is clear resistance to changing over to free services. This resistance is more pronounced in the case of tertiary level services.

Table 3: Percent Public Health Expenditure by Region in the World	
Country/Region	Public Expenditure on Health as percent of total health expenditure
India	29.20
Average of High income countries	65.10
Average of Low income countries	38.78
Average of Middle income countries	52.04
World	62.76
Source: World Bank Database (http://data.worldbank.org/)	

- Drug supplies neither cover all requirements nor are they uninterrupted, making outside drug prescriptions with out of pocket expenditures common.
- Diagnostics are the main source of user fee collections across the nation, and hospitals are loathe to let this avenue go.
- The practice of free diet was given up in the nineties and is being revived with some difficulty.
- Informal charges (read demanding payments by corrupt means) remain and are highest in states where salaries are very low or not paid on time.
- Travel to the facility is a huge cost, though a number of assured patient transport services have somewhat reduced these costs.
- Where referrals to private sector become necessary - because of a lack of services in the public sector, the government does not accept the costs of care incurred in such referrals.

The constraints enumerated must be systematically addressed while expanding the scope of free and comprehensive services to include all disease categories.

One other important challenge relates to inefficiencies in public financial flows. Facilities with high patient loads run out of funds in weeks, whereas facilities with poor patient loads do not expend their money. Since the latter are numerically larger, a lot of funds are locked in the pipeline, while the quality of care in high

volume facilities remains very poor. Thus, while increasing investment is urgently needed, districts should have the capacity to deploy financial and money responsive to peoples requirements rather than mechanically distribute these based on centrally decided norms.

Finally, **JSA has been advocating a major increase in financial allocation by central and state governments to the health sector – at least to 5% of GDP** as recommended by the WHO. India has for too long had among the lowest levels of public expenditure on healthcare in the world (see Table). One of the declared goals of National Health Policy and the National Rural Health Mission has therefore been to increase public health expenditure to 2 to 3 percent of GDP. However, current public health expenditure in the country stands at 1.06% of the GDP.

Over the years states have been starved of funds through a variety of fiscal mechanisms, but even during the *11th Plan period the states actually performed better than the centre in allocation of funds for health care. The Eleventh* Plan had projected an allocation of 0.87% of GDP by the Centre and 1.13% by States by 2011–12. At the end of the Plan period the allocation stood at 0.32% of GDP by the centre and 0.68% of GDP by states. The major shortfall was a consequence of the meagre Central allocation.

Community Processes and Accountability

Recognizing that health is a product of processes, which are largely located at the level of the family and community, any programme for universal health care must aim to involve communities as active participants rather than merely as passive beneficiaries.

Community processes are largely mediated through organisations- elected local bodies, self help groups and other community based organisations, and official committees set up by the health department where public participation is provided for. In addition non-government organisations can play a major role in articulating and sometimes acting on some specific concerns of the community. NGOs also can play a major role in adding technical capacity.

One major development under the NRHM has been the appointment of ASHAs. There is a need to find a balance between safeguarding her rights as a women worker -- whose work has

to be valued and adequately remunerated – and the need to envision her as a community based worker with the spirit of voluntarism and activism. Despite poor status and remuneration, in many areas, ASHAs have begun to play a crucial role in strengthening demand for health care services. The time is ripe to overcome the current limitations and deficiencies of the ASHA programme and to begin considering the nature and needs of a second community health worker, while securing the working conditions and performance of the first.

One of the central issues in many discourses about strengthening public health care systems is accountability and transparency. One set of measures attempted is to create participatory structures -- where there is both civil society and multi-stakeholder participation and a degree of transparency. Such structures include state and district health societies, rogi kalyan samities (RKS) and village health and sanitation committees (VHSC). Experience shows that these forums can be used by a dynamic leadership to improve the quality of inter-sectoral participation and the social support needed for the health sector. However, functional mechanisms of accountability remain the chain of command leading to the elected minister, legislature and judiciary at the top.

Community based monitoring processes, integrated in the NRHM, have shown to be capable of improving performances of public facilities when there is a direct dialogue with the community. In addition, larger systemic problems need to be raised and these need to be addressed through appropriate broader policy decisions and actions.

One also needs to keep in mind that public systems are plagued by a high degree of internal inertia, negativity and loss of morale. Many systems of monitoring and penalties work to harass the honest health care provider- and the innovative and dynamic manager. It is a well known axiom that those who take less initiative and do less are also much less vulnerable to criticism, while those who are active and contributing in a major way could get victimized more often. The challenge is therefore to build a positive work environment and also support for the honest service providers -- who are more often than not victims of poor working conditions and corrupt leaderships.

Corruption is not an aberration in the system – it is one dimension of power relationships within the system that promotes rent seeking at all levels. A fight against corruption is possible if

we understand the dynamics of the system. In many states, the single biggest source of corruption is the appointment of the chief medical officers, district medical officers and of directors of health services. In some states which are most notorious for corruption, almost all CMHOs are holding their posts on an ad hoc basis. They pay a 'rent' for securing their job, and then a regular rent thereafter to keep the job. To pay this rent, they must demand the same from both junior officers and vendors- making cuts into legitimate payments. Vendors often advance the money used to buy the job.

Another major source of corruption is in procurement of consumables and equipment. The TNMSC example has been discussed earlier. We only add another benefit: in TN, by removing drug procurement from the functions of the directorate it reduced the pressures for corrupt appointments of directors of health services.

A third major source of corruption is infrastructure creation, leading to poor performance, slow utilization of resources and a failure to meet targets. A further source of corruption is transfers and postings. In many states once transfer season comes, a large number of providers have to pay to keep their positions.

An emerging avenue of corruption is kick backs in public private partnerships and in contracting out programmes to non governmental agencies. Over a period of time providers with integrity and efficiency do no survive, and the market becomes dominated by unethical players. We see this problem in the NGO sector in many states.

It follows there that the main demands of peoples movements should be for :

- A transparent appointment of chief medical officers of the district and directors at the state level.
- Robust and transparent institutional mechanisms for infrastructure and procurement with every process benchmarked to TNMSC as a standard.
- Transparent and fair postings and transfers.
- Transparent grant-in-aid mechanisms for NGOs and fresh procurement rules for academic and not for profit partnerships.

- Transparent and appropriate procurement of commercial service providers, so that neither leakage nor monopoly results.

A grey area in this scenario is the issue of private practice by public providers. First, where such practice is allowed, they must work under clear rules that prevent conflict of interest situations – viz. no kick backs for diagnostics and no referrals to a facility where the public provider or his or her near family are on the board. Also one could experiment with progressive withdrawals of private practice- like first withdrawing it from medical educational institutions accompanied by better conditions of professional work and pay packages.

In conclusion, greater investment and addition of human resources will be needed, but in addition the strengthening of public health systems requires major institutional innovation and capacity building at all levels of the system. Secondly regulation of the private sector is urgently needed to reduce the corrupting influence of a lucrative, unregulated private sector which acts as a powerful force to attract doctors away from Public Health System , One of the philosophical foundations of this approach is that healthcare is not seen as a commodity that lends itself to packaging and purchase mechanisms but rather as a relationship of trust that has to be established between a health team and the community it serves. The role of the government is to build systems that establish and protect such a relationship.

Private Health Care providers in the context of movingtowards Health Care for All

Private health care in India: massive but unregulated, often irrational and sub-standard

India's Health Care System is one of the most privatized in the world. Thanks to the policy of the government to encourage the growth of the private sector, especially since the 1990s, the **share of private sector** in various components of health care in India today is approximately as follows:

Medical graduates	90%
Post-graduate doctors	95%
Outpatient care	80%
Indoor patients	60%
Medical colleges	30%
Manufacture of medicines	99%
Manufacture of medical instruments	100%

After Independence, there has been tremendous growth and development of the private medical sector. Due to insufficient expansion of the public health system and overall private sector friendly policies of the state, the vast majority of doctors passing out from medical colleges have joined the private sector. This trend has accelerated with production of higher proportion of postgraduate doctors since the 1970s. Iin 1950 there were 60,000 MBBS doctors, now there are 7.5 lakh MBBS, equal number of AYUSH doctors and most of them are private providers. Added to this is the tremendous growth of corporate hospitals, starting with the Apollo Hospital in Chennai in 1983. The neoliberal policy has fuelled the growth of corporate health care from 1990s. As per Centre for Monitoring Indian Economy, during 2003-2008, sales of 30 companies in healthcare sector have galloped. For example that of Apollo Hospitals Enterprise Limited increased from Rs 500 crores to Rs 1458 crores in this period. In 2008, the income of Apollo Hospital alone was of Rs. 1150 crores, 28% more than previous year's and profit was 102 crores, 51% more than previous year.

Despite it's rapid growth and large size, the private medical sector in India suffers from a wide range of serious problems and it is widely acknowledged that these arise due it's profiteering linked with complete lack of regulation This has led to huge urban-rural divide, massive wastage, exploitation due to excessive/irrational medications, frequent exploitation of patients by overcharging and unnecessary interventions, major variations in quality and overall substandard care, violation of patients' rights. This is compounded by the exploitation by pharma industry through manufacturing and sale of irrational medicines and irrational drug combinations, costly brands, overpricing. Added to it during the last 20 years there has been proliferation of private medical colleges and proliferation of unregulated medical equipment industry. Thus overall barring some centres of excellence, private medical care in India is substandard and unnecessarily costly. There has been complete failure of regulatory agencies like the Drugs Controller, the Medical Council of India not to speak of complete lack of self-regulation by the professional bodies like the Indian Medical Association (IMA).

Starting from this background of present overwhelming presence of private health care in India, it would be quite a task to reach the goal of health care for all. Today most people have to pay to access health services and still have no assurance of quality and rationality of care. Moving ahead from this situation, we have to envision a process through which we can achieve the goal of Health Care for All, located within the broader vision of Health for all. While this would involve massively expanding, strengthening and reorienting the public health system, given the majority of health care resources today under sway of the private sector, this sector cannot be ignored or wished away. In fact even expansion and improvement of the public health system is in some ways linked with reshaping the private medical sector, since key aspects such as availability of doctors, legal or illegal private practice by public doctors, referral patterns etc. are linked with current dominance of the private sector. In context of such a broader framework, we will need to think about how to deal with the massive private medical sector, keeping in mind its current serious problems, as well as the large scale health care resources that are currently under its sway.

Two approaches to dealing with the private medical sector while moving towards Health care for all

Naturally, if the public health system expands substantially and begins to provide quality care to a large portion of the population, the private sector would be put in a situation where it must either function in a more responsive manner or become progressively irrelevant. However, since such major expansion of the public health system would take some period of time, and even to enable such expansion in the near future, resources such as specialist doctors have to be reclaimed and the influence of the private sector has to be rolled back, we need to decide how to deal with the existing private medical sector while moving towards HCA. In this context, two diametrically opposing approaches are available to us today. ***Either public resources would be made to serve private benefit, OR private resources would be made to serve public benefit.***

The choice between these two approaches is one of the core contentious issues that lies at the base of current debates about UHC / HCA in India. Today a dominant strand in the establishment is advocating the former approach under the rubric of publicly funded health insurance schemes and certain variety of 'Public-Private partnerships', where with amplification of certain existing models, large scale public funds would be handed over to the private medical sector without any effective regulation, accountability or rationalisation of this sector, and in a manner that would further weaken the public health system.

In Jan Swasthya Abhiyan, as we strongly oppose this dominant approach of using public resources for private benefit, which has been articulated most coherently in the Planning commission's 'July draft' Health chapter, we need to start discussing how to develop the alternative approach of using sections of private resources for public benefit. This would involve in-sourcing of certain kinds of private providers (including not for profit providers) in a manner that would strengthen and complement the public health system instead of weakening it, using such providers where and if necessary and under certain terms, conditions.

In this context, we might learn from certain other countries which have achieved the goal of Health Care for All, where there has been a departure from the domination of the logic of the market in health care. The decisions about health care are based more and more on the logic of social medicine, and less and less

from the consideration of health care as just one more arena of profitable business. For this to happen in India, there is no doubt that the Public Health Services would be the backbone of HCA, and only an expanded and strengthened Public Health System can lead such a process of taming private providers and leading sections of such providers along a path towards socialization of health care. While the aspect of strengthening and expansion of the Public Health System has been covered in another section, here let us discuss how sections of private providers might be reshaped in the process of moving towards Health care for all.

A key question is - would we really need to insource sections of private providers to achieve 'Health Care for All' in India in the near future? If yes, what would be the approximate scale and nature of this insourcing? To take the example of urban areas, in India in coming 5 to 10 years, about 5 lakh doctors would be needed in cities to achieve the goal of one doctor per thousand population. Currently only about 60,000 doctors are employed in urban PHFs in India. It is quite unlikely that all the requirement of remaining nearly 4.5 lakh doctors can be met by recruitment into the public health system (which would involve a nearly ten-fold increase in the public health system in urban areas in next 5-10 years). During the next 5-10 years, even if special efforts are made to recruit doctors in urban PHFs and new medical colleges are opened, most doctors in urban areas are likely to continue in various forms of private practice or private facilities. A section of such providers will have to be contracted into Public Health Systems in significant numbers, at least for urban areas, regulated by certain terms and conditions, and in a manner that strengthens or complements efforts to expand the public health system. This is especially valid while we consider how to make rational specialist care available to all those who genuinely require such care, since today 95% of medical specialists are in the private sector.

Such contracting-in of a section of private providers would have to be based on appropriate regulations and guidelines, due to which these contracted doctors would act more as an extension of the Public Health System. They would be so regulated that they conform to scientific, ethical medicine in tune with the logic of social medicine. Under this contract, it should be mandated that while they have a decent and secure income, contracted private providers too would have to practice rational care, and that they will have to tune their clinical practice

with the goal and logic of Public Health. We need to see that in the 21st century, if there is sufficient public mobilization and political will, 'private interests' will have to progressively lose ground in this field, because of the nature of modern clinical and social medicine which works best when there is public ownership and control over the means of health care delivery. In a socially regulated system, the scope for commercial cheating and exploitation by individual practitioners would be eliminated, and in fact, as in case of the original NHS model in Britain, insourced private practitioners would then remain private only for the name's sake.

Whatever model of moving towards health care for all is adopted, adequate laws, policies, regulatory structure will be required to ensure effective regulation. We also need to recognize that the private medical sector is not a monolithic entity, and the strategy we adopt for different layers amongst private providers would have to be quite different. Let us look at these aspects in some more detail.

An essential and overdue step: comprehensive legal regulation of private providers with a participatory framework

As argued above, comprehensive regulation of the private medical sector in India is absolutely essential. Certain regulations would be applicable across the board for all health care providers (related to physical and humanpower standards, patient rights, equity in distribution, guidelines and protocols for rational care, broad norms on costs of care) while some further regulations would be enforced regarding providers involved which are contracted into public health systems (systematic auditing of rationality of care and control on costs of care) although even the latter regulations would be expected to have a progressive, system-wide effect. Key areas requiring regulation would essentially include the following:

a) Standardization of structures and human-power of facilities to ensure quality of care
b) Protecting patients rights
c) Equalizing accessibility / distribution of establishments
d) Standardization and rationalisation of process of care based on standard protocols
e) Rationalizing and containing costs of care

To achieve such appropriate regulation of Private Medical Care in a public systems led move towards health for all would require the following kinds of measures:

1. Formulation of adequate law / reformulation of existing law through multi- stakeholder (including citizens') participation

The current Clinical establishments registration and regulation act lays down certain very broad guidelines for regulation, and it has currently been adopted by only a few states. On one hand, the act needs to be broadened since it does not mention the principles of patients rights or ensuring public health obligations of private providers. Such reformulation should be based on a consultative process, to take into account the concerns of various stakeholders including health rights organisations and patients groups, so that no serious lacunae remain. At the same time the act needs to be made universally applicable in all states.

The national rules under the current act have now been formulated, hence corresponding rules need to be adopted by states. Detailed framework of patients' rights must be included in such rules. Further the rules should include specifying a decentralised framework of implementation by an autonomous regulatory authority guided by multi stakeholder bodies (including civil society organizations working on Health Rights) to promote and monitor the regulatory work.

The govt. claims that the Clinical Establishment Act 2010 would serve this purpose of regulation of private providers. Unless an effective, adequate regulatory authority is put in place, with the structure to implement the regulations, the talk of regulation would mean only empty words. It is the ministry that would have to set up the authority, but with sufficient, autonomy and governance for it to be effective. Further it has to be set up at both national and state levels with clear roles for each.

2. Policy and regulatory structures to implement the law

Appropriate agencies/structures would be required, which must be adequately supported by resources, to operationalise regulation and standardisation. These bodies would be in two parallel streams:

a) **Health care authorities** at various levels, which would be offices with full time, professional staff entrusted with direct implementation of regulation

b) **Health boards or councils** at various levels, which would be multi-stakeholder bodies with variety of representatives, meeting periodically and carrying out broader planning, decision making, standard setting and monitoring of regulation.

There will be need for binding norms like setting of standards and protocols which will restrict the scope of irrational, insensitive care. Combined with montoring by relevant authorities, there is need for participatory monitoring (on the lines of Community Based Monitoring) by multi-stakeholder bodies that may be similar Health Councils in Brazil. Further a user friendly, independent, redressal mechanism at local level would be needed which will have to be widely publicized.

The overall objective of such a regulatory system would be to move towards a more socialised, equitable and accessible health care system providing quality care with participatory governance (not confined to top-down, bureaucratic regulation) including elements of self and social regulation.

Principles to guide interaction of private providers with the public health system, while moving towards Health Care for All

We are arguing that certain contracted private doctors and facilities should act as an ***extension of the Public Health system*** by following appropriate guidelines. However we need to keep in mind that so far in India, much of the interaction between the public health system and private providers (often labeled as 'Public-private partnerships') has been deeply problematic, since in most of these models, while public funds are handed over to private providers, their mode of functioning has not been brought in line with public health logic, and they may even tend to replace or weaken public systems. We are envisaging a qualitatively different form of interaction, where certain private facilities are contracted and given a more public character to fill gaps and complement and strengthen the public system. But for this to occur, the ***terms of engagement with the private providers*** should be clearly formulated. Towards this end, guidelines formulated by in the JSA's draft booklet 'Towards People's Health Plan' prepared during the National Health Assembly II in Bhopal, 2007 should be considered. We can build on some of these guidelines and modify them as follows:

- Clearly demarcate the private commercial sector from the not-for profit and voluntary sector in health care provision and treat them differentially.
- Quality and Cost Regulation of service delivery and a transparent system of monitoring would have to be in place.
- The objective would be to fill key gaps in the public system while ensuring essential services to people. Hence such interactions should supplement and strengthen the public sector but not substitute or weaken existing public health care services in any situation.
- Expanding/bringing in investment working for public health goals, which would mean no transfer of assets and resources from public ownership into private hands.
- Prompt payment with dignity for the private sector partners so that ethical low budget proprietary services in smaller towns are favoured.
- Ensuring that efficiency is based on better management practices and not based on unfair wage structures and compromised social security benefits, especially for women health care providers like ANMs and nurses.
- Putting in place kick back statutes, that ensure there are no referrals with conflict of interests, especially where the same providers is working in both public and private facility.

It may be reiterated that establishment of a strong regulatory structure with oversight by bodies including community and civil society representatives should be a pre-condition for any interaction between the Public health system and private providers. The regulatory framework should be participatory and would encourage self-regulation. Secondly all such providers will have to respect, ***observe patients' human rights*** and should have adequate, just grievance redressal system. Further *all publicly funded services should be regarded as a form of public service in terms of their accountability obligations* – such as respecting Right to information, allowing Community based monitoring, and regular reporting to various public bodies.

Development of any such framework is critically dependent on three key elements. These are *significantly enhanced public regulatory capacity* (which is presently weak and prone to corruption), *systematic participatory accountability processes* (which can keep the regulators on track and could strongly present community feedback to ensure appropriate provision of services) and *development of pro-people, rational technical norms, guidelines and protocols* which would be essential to operationalise such regulation.

Taking a differential approach to various sections of the private / non-public medical sector

To move towards engaging the private sector in a much larger scale, we need to win over a section of private (including not for profit) health care providers around the need to move towards health care for all, , and to neutralize other sections of these providers who would for reasons of vested interests would otherwise have opposed it. The range of private and non-public providers in our country is extremely diverse and even bewildering, and we cannot paint all of them with the same brush, in either black or white. Keeping this in mind, although regulation is a comprehensive, universal non-negotiable process, regarding further insourcing of certain sections of the private sector, *we would need to take a differential approach based on how much amenable each section is to some degree of socialisation*.

First of all we may keep in mind that historically we have a significant section of ***charitable, mission and not-for profit health care facilities***, many of whom are working in less developed, rural and remote parts of the country. Many of the hospitals and smaller facilities involved with networks like CHAI and CMAI as well as many NGO-run health facilities would fall in this category. Such facilities today face their own share of problems due to the larger pressure of market-driven health care, especially its negative influence on doctors. Such facilities should be identified based on sturdy criteria (including proportion of patients treated free and range of rates charged for standard services) and prioritized for inclusion in the HCA system. With provision of certain level of public funds, they would be able to function much more effectively and could fill certain critical gaps as well as provide a model for other private providers.

Next we should keep in mind that beyond the more or less genuine not-for-profit providers, there are large numbers of ***hos-***

pitals which have been registered as trusts to gain public subsidies and income tax exemptions, however they may not necessarily function in a charitable manner as per their declarations. While massive public subsidies,including cheap land in prime urban areas, have been availed of these facilities, they often do not provide the mandatory 20% free / subsidized beds to poor patients, and this has been an issue of court orders and social demands. This can be done by pinning them down to their declared objectives in the Trust Deed ***through participatory monitoring and effective redressal mechanisms***. Secondly ***more stringent laws, rules*** will have to be formed so that all the aspects of their functioning follow the overall the logic of the HCA system. The current practice of indulgence in money-making and yet showing no profits in the balance sheet can not be continued!

Since leaving provision of these free beds to the hospitals themselves is open to manipulation, these 20% free / low cost beds (these number in tens of thousands of prime hospital beds across the country) should be mandated to be insourced into the public system, and managed as public resources in conjunction with the public health system. Any 'trust' hospital refusing to fulfill this obligation should be required to pay compensation not only for massive subsidies availed, but also retrospectively for all the free care that has been denied by them to poor patients since years and even decades. This measure would make available significant additional resources to the public health system which could fill gaps especially related to secondary and tertiary care in urban areas.

Further, we may keep in mind that in India we have a very large, ***numerically predominant section of general practitioners*** running their small individual clinics. In this 'unorganised' sector, the private practitioners are like other middle class professionals who sell their services to people. We need a strategy about these clinics in our conceptualization of move towards health care for all. . Their practice should be regulated as regards their location, quality and pricing. Secondly, the regulated doctors required for UHC could be contracted in sufficient numbers into the publicly managed Health Care for All system by the state (for example, as in case of the original NHS in UK) especially in urban areas. Currently they are subsumed under the ***logic of market, being sucked in as agents of the medico-industrial complex*** and indulge in commercial exploitation of patients.

With proper contracting and regulation, the scope for individual practitioners for commercial cheating and exploitation would be progressively eliminated.. In fact the private clinics would then remain 'private' more or less nominally; in effect they would primarily serve social purposes as they would be indistiguisable from public ownership. Here too, the basis for involving such practitioners would be to fill existing gaps in the public system (which are major for example related to outpatient care in urban areas, where the private sector largely dominates) and to involve doctors willing to work in a regulated system, which may include younger doctors and those not interested in continuing in the commercial rat-race. Insourcing of individual specialists to public hospitals which have major vacancies of specialists also needs to be pursued much more systematically with elimination of bureaucratic obstacles and corruption in such insourcing, which can significantly strengthen the services of public hospitals. It may even be envisaged that over a period of time, some of such publicly insourced doctors might opt for joining the public health system and such options could be consciously promoted.

Next, the position of ***small and medium sized private hospitals*** is contradictory, since on one hand they tend to function more in an 'investment-profit making' mode, but on the other hand, with expansion of corporate and large hospital dominated chains, they are feeling the pressure of being pushed out of the market. Discussions with small hospital owning doctors especially in some cities shows that they are beginning to seriously feel the compulsion of having to compete with the big corporate / private hospitals (which often offer more 'amenities' and have glamour value for patients, and offer higher 'cuts' to referring doctors). Further removal of user fees, free drugs and improved quality of care in public hospitals would undermine their position in the market. Keeping this in mind, their involvement should be actively undertaken through clear contracts which specify the package of services they would provide- but ensuring proper regulatory and monitoring systems in place.

Finally, corporate and large private hospitals are because of their very nature, least likely to positively respond to any genuine health care system where the leadership is with the public health systems. Most of the members of this section would be least amenable to serve social goals and are least likely to be part of a genuinely regulated UHC system. The strategy towards this sector would depend upon ***balance of socio-political***

forces. In any case all corporate hospitals will have to be regulated even if all of them remain outside the UHC system. An ***unregulated corporate sector would adversely affect the overall culture in the health care*** even if it serves only the rich. Progressive social control over the ***medico-industrial complex*** with internal democratization should be the direction we should advocate. Actual progress in this direction depends upon level of political pressure that can be generated towards this end.

Further it may be kept in mind that the ***internal functioning of all private facilities*** would have to be democratized - the doctors including duty/resident doctors, nurses and other staff working in these hospitals should have adequate say in the functioning of these hospitals and their democratic rights should be respected. Trade unions or associations of employees of such staff, wherever they exist, could be an ally in demanding regulation of private medical facilities.

Health Insurance: The Road to Health for All?

In 2007 the Government of Andhra Pradesh launched an insurance scheme that was designed to protect patients from the 'catastrophic' impact of out of pocket expenses incurred on hospital care. Termed as the 'Rajiv Arogyasri' scheme, it soon became a flagship programme of the Andhra Pradesh government and came to be held out as an example of the state Government's commitment to providing affordable health care to the poor. The scheme was a major election plank of the ruling Congress party in the 2009 elections, and many commentators later suggested that Arogyasri's success was a major factor in the sweeping mandate that the Congress received.

Arogyasri's apparent utility was quickly picked up by the Central Government and a nationwide scheme modeled on Arogyasri was launched in 2009 – called the Rashtriya Swasthya Bima Yojana (RSBY). In the UPA-II's rather bare cupboard of programmes for social welfare, the RSBY scheme has been held out as a major achievement.

Similar state level schemes have also been launched or are in the process of being launched in Kerala, Tamil Nadu (originally called the Kalaignar Scheme, since renamed by the new state government), Delhi (Apka Swasthya Bima Yojana), Karnataka and Maharashtra (Rajiv Gandhi Jeevandayee Arogya Yojana). The roll out of these schemes have been impressive – by the end of 2010 an estimated 247 million people (25% of the country's population) were covered by one or more of these schemes. Coverage has, since, expanded even further. This is a huge jump from the pre-2007 situation when the two social insurance schemes in existence were the Employees State Insurance Scheme (ESIS) launched in 1952 and the Central Government Health Scheme (CGHS) launched in 1954. The former covers employees in the organised sector (about 7 percent of the country's work force) while the latter covers employees working for the government. Both are funded through co-payments made by employees and employer.

As plans are now being readied to launch the present government's vision of a reformed health system, through the lens of the Twelfth Five Year Plan, insurance schemes such as the RSBY are poised to get even larger attention and support. It thus becomes necessary to critically assess the underlying

elements of these insurance schemes. Particularly so as it is being claimed that these initiatives will protect people from the impact of catastrophic expenses on medical care, because of which an estimated 6 crore people are driven below the poverty line every year.

Content of the Health Insurance Schemes

Let us step back to understand the content of these schemes and their underpinning logic. All these schemes are meant for hospital care only. All of them have a list of procedures which are covered – which means that reimbursements are limited to this list. A fundamental innovation that has been introduced in these insurance schemes is that patients are provided a 'choice' of accredited institutions where they can receive treatment. These institutions can be in the public or the private sector. Like any insurance package these schemes have a ceiling for reimbursement. This ceiling varies – it is set at Rs.30,000 per family of five in the RSBY schemes, while some state schemes such as the Arogyasri reimburse up to Rs.1,50,000 or more. While the RSBY scheme started off by being restricted to BPL families, many state schemes now cover non-BPL families as well. All these schemes are publicly funded – i.e. the annual premiums for beneficiary families are paid by the Government. In the case of the RSBY scheme the central the cost of the premiums is shared by the Centre (75%) and state (25%). The state schemes are funded by the state budgets.

A fair question to ask is, given the outline of the insurance schemes like RSBY, shouldn't such schemes be supported? After all they are paid for entirely by the government and they reimburse expenses incurred – often very steep – to access care that involves hospitalization. The schemes have the added advantage of being cashless, i.e. payments are made directly to the provider and the patients do not have to pay themselves. The RSBY has also introduced 'portability', i.e. those registered in one place can avail of the scheme when they move to another location.

To arrive at a reasoned answer to this question we need to examine this scheme in the context of the entire health system. There are two fundamental pillars of insurance schemes of this kind. First, they operate on the logic of what is called 'spilt between financing and provisioning'. What this means is that there is a clear separation between the financing of services provided,

and the facilities where these services are provided. Thus, in the case of all these schemes, while the financing is through public resources (central or state government funds) the treatment can be provided by any accredited facility. Such facilities can be either public (i.e. government hospitals) or private. In practice, a large majority of accredited institutions are in the private sector. The second pillar of all these insurance schemes is that beneficiaries are insured against a set of ailments that require hospitalization (unlike the old ESIS and CGHS schemes which are supposed to cover all forms of care). So beneficiaries are not guaranteed care for all ailments – in other words it is not a promise to provide comprehensive health care, but to provide care for a pre-defined package of procedures.

These basic tenets of the insurance schemes have to be understood in the context of the country's health system. The public system is under resourced and access to it is difficult for a very large number of patients. Over 70% of health care costs are borne by patients themselves as they are forced to look for care in the private sector. The private sector is almost entirely unregulated and is a mix that ranges from primarily unqualified practitioners in rural areas, charitable institutions, small private nursing homes and hospitals, and large chains of corporate hospitals. Over the past decade there has been a huge expansion in the last category – of chains of corporate hospitals. These have expanded to fill in the void left by an inadequate public system and operate almost entirely in towns and cities. The public system still caters to almost 40-45% of hospitalized patients, while over 80% of out-patient care is accessed through the private sector. Thus, a majority of expenses incurred by patients is in out-patient care.

Impact on the Health System

Let us now examine the effect that the insurance schemes have on the existing health system. The split between financing and provisioning explicitly opens the door for participation by the private sector. In most situation a large majority of accredited providers are in the private sector. Supporters of insurance argue that it shouldn't matter where people get medical care, as long as they are assured good care. They also argue that 'competition' between different providers will improve the quality of care. Unfortunately evidence available suggests something totally different.

A recent analysis of the Arogyasri scheme in the Economic and Political Weekly (N.Purendra Prasad, P.Raghavendra, Healthcare Models in the Era of Medical Neo-liberalism: A Study of Aarogyasri in Andhra Pradesh, Economic and Political Weekly, October 27, 2012) provides very interesting data. The analysis notes that "*The Aarogyasri Trust has empanelled 491 hospitals in the state, of which nearly 80% are in the private sector while the remaining 20% are government hospitals. Although the Aarogyasri scheme is meant for poor villagers, there is not even one private hospital in the rural areas, while the distribution of empanelled government hospitals in rural and urban areas is almost even*".

Competition and False Choice

Unfortunately the choice provided by such a model is a false choice. For people to exercise their choice information is crucial. In the case of medical care patients, especially poor and vulnerable patients, have little or no information. Patients (now called consumers!) are ideal candidates for being enticed by the private sector, especially the well resourced corporate hospital chains. They are enticed by fraudulent claims hidden in the garb of technical jargon. In the past few months there have been several stories in the media regarding the sharp rise in hysterectomies (operations involving removal of the uterus) since the introduction of the RSBY scheme.

In Chhattisgarh, the director of health services, under public pressure, appointed a fact-finding team and suspended doctors involved in 22 cases, where it could be proved that the operations for hysterectomy were conducted without medical reasons. Dainik Bhaskar reported that just one private hospital (Gupta Hospital in Dhamtari) conducted 604 hysterectomies in 900 days. In comparison, the government-run Ambedkar Hospital in Raipur conducted just seven such operations in the same period. Other media reports indicated that in Bihar an estimated 16,000 hysterectomies, most of them deemed unnecessary, have been conducted. Everybody in the know acknowledges that these reports are just the tip of the iceberg. Unethical practices have become the cornerstone of the RSBY scheme in many parts of the country – leading to unnecessary investigations, medication and surgeries that only help the profit hungry providers.

The EPW analysis reports how 'Arogyamitras' are appointed by private hospitals to scout around for patients who can be

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enticed to get operated upon in private hospitals. The private hospitals also 'cherry pick', i.e. they pick and choose those patients that provide the highest returns and refer others to government hospitals. The refuse patients who are likely to have poor outcomes or are not likely to provide good returns. Government facilities are not structured to compete in the 'market' for health care, and gain little even if they are empanelled. This is thus the kind of choice that the poor and vulnerable are provided – a choice based on false motivations and enticements by profit hungry private hospitals.

Limited Package and Skewed Priorities

We now turn to the other pillar of the insurance model – **only a pre-approved package of procedures are covered, and only applicable if they require hospitalization**. This leaves out not just important conditions that require hospitalization, but the entire range of ailments that are treated through out-patient care. There is clear evidence that the major burden of diseases lie outside the packages covered by the insurance schemes. These include almost all infectious diseases that are treated in out-patient settings – including those that require prolonged treatment such as tuberculosis. **Most chronic diseases like diabetes, hypertension and heart diseases also get left out of the package**. A cancer patient who needs to take expensive treatment for months would not be included unless hospitalized! Rough calculations indicate that the packages cover 2-3% of the actual burden of disease that exists in a community.

Such skewed priorities end up by distorting the existing health system. In AP the Arogyasri scheme draws 25% of the state's health budget while covering for 2% of the burden of disease[1]. Insurance schemes, thus, draw away resources from the already resource-starved public health system and fattens the coffers of corporate hospitals. In other words public money is being squandered to strengthen the already dominant corporate private health sector. The same resources, if used to strengthen the public health system, would leave the nation with assets that are under public control and can be used for public good. A study done by the Public Health Resource Network (PHRN) and the Centre for Social Medicine and Community

[1] A Study of Aarogyasri in Andhra Pradesh, Economic and Political Weekly, October 27, 2012

Health (CSMCH), JNU, in Chhattisgarh showed that the revenues of Govt. institutions empanelled under RSBY have not increased, while at the same time previously available maintenance funds have been withdrawn.

Importantly, perhaps the worst harm that such insurance schemes cause is to **distort the entire structure of the health system**. Good health systems are like pyramids – the largest numbers can be treated at the primary level where people live and work, some of these need to be referred to a higher level of care (secondary level like community health centres), and a few would need specialized care in specialty hospitals (the tertiary level). **An insurance system that sits on top of the health system overturns the pyramid and starves the primary care facilities**. In 2009–10, direct government expenditure on tertiary care was a little over 20 per cent of total expenditure. However, if this were added to the expenditure on the insurance schemes that focus entirely on hospital based care, the total public expenditure on tertiary care would be about 37 per cent of the total expenditure.

As noted earlier, the current insurance schemes (RSBY at the national level and state level schemes such as the Arogyashri in AP) cover for secondary and tertiary level health care for in-patients – largely provided in private facilities. The High Level Expert Group (HLEG) — set up by the Planning Commission as a preparation for the 12th Five Year Plan — had said that use of independent agencies in the private sector and insurance companies under schemes such as the Rashtriya Swasthya Bima Yojana (RSBY) *"fragments the nature of care being provided, and over time, leads to high healthcare cost inflation and lower levels of wellness. ... since there is virtually* ***no focus on primary level curative, preventive, and promotive services*** *and on long-term wellness outcomes, these traditional insurance schemes often lead to inferior health outcomes and high healthcare cost inflation."*

Patients are pushed from more rational primary and secondary level care into often less rational and expensive tertiary care. It is no wonder that in Andhra Pradesh, due to the Aarogyasri scheme, the proportion of funds allocated for tertiary services increased from 16% to 39%, whereas proportion of funds allocated for primary care reduced from 69% to 46%. This fragmentation of health care is also associated with 'cherry-picking', i.e. illnesses which bring more revenue to the provider, are selectively preferred by the provider.

Further in both the RSBY and the Arogyashri schemes,, there are prescribed ***clinical protocols or Standard Treatment Guidelines.*** In their absence profit motives continue to guide clinical practice, leading to ***unnecessary interventions, wastage of resources and poorer health outcomes.***

There are other major deficits in the structure of the insurance schemes. Enrolment is patchy and the claims of being cashless and portable are not universally true. The PHRN-CSMCH study in Chhattisgarh shows that enrolment among entitled beneficiaries continues to be low (30 to 50 %) and no enrolment has been done in remote and inaccessible villages. It also showed that claims could take 6 months to 2 years to be settled in some cases.

Conclusion

The health insurance model was introduced to protect people from the catastrophic impact of health care expenditure, especially among the poor and the vulnerable. While such benefits would have accrued to a small number of beneficiaries genuinely requiring hospital care, by and large the schemes are inimical to the development and sustenance of a robust public health system. The Ministry of Labour, which administers the RSBY scheme, would like to promote the scheme as pro-worker and pro-poor. This is a gross travesty of the actual situation. The only guarantor of secure access to quality health care is a well resourced and accountable public health system.

The working of the insurance schemes should be comprehensively enquired into, especially the very serious charges against private hospitals that they are attempting to 'milk' the scheme by resorting to a range of unethical practices. The working people of this country deserve much better, and trade unions and peoples organisations need to be involved in a thorough scrutiny of the RSBY and other like schemes.

Attention also needs to be directed at the gross neglect of the Employees State Insurance Scheme (ESIS). Though a large infrastructure has been created under the scheme, it is poorly resourced and poorly managed. As a result its benefits are grossly underutilized. Wage earners beyond the Rs.15,000 limit do not have access to any social protection measures for health care. The poor coverage and utilization of the ESIS forces a majority of workers to pay for health care.

Ensuring Access to Medicines for All

Access to essential medicines is a major determinant of health outcomes and an integral, and often crucial, component of health care. It has been estimated by different sources that 50% to 80% of the Indian population are not able to access all the medicines that they need. The World Medicine Report of the World Health Organization finds that India is the country with largest number of people (649 million) without having access to essential medicines. Given that India today is the 3rd largest producer of drugs (by volume) in the world and exports medicines to over 200 countries, this is clearly an unacceptable situation.

In an ideal situation all medicines that are researched and marketed should enhance therapeutic goals and should be available to all those who require these medicines. Unfortunately the actual situation in the medicines market is much more complex. There are several issues that need to be addressed in order to ensure access to all medicines that people need.

Essential Drugs Concept and Free Medicines Initiative

An approach to ensuring access to medicines has been promoted by the World Health Organisation since 1978. It is called the "Essential Drugs" Policy. The policy starts from an understanding that it is necessary for countries to prioritise which medicines should be made available to all its population. Each country would need to develop its priorities based on the country's existing demographic profile and disease prevalence rates. The WHO, periodically, publishes a "Model" list of essential drugs (the first model list was published in 1978), but countries are encouraged to develop their own model lists, based on local conditions.

An Essential Drugs List also needs to be dynamic, that is it needs to be updated periodically (every 2-3 years) in order to be able to capture recent advances in therapeutics and changes in disease prevalence scenarios.

It is only recently that India has tried to implement an essential drugs policy. While India has periodically revised its national essential drug list, the list has not been used to ensure access. In the past few years national and state lists have been up-

dated and most states have a graded list. The goal under the NRHM has been to make available all essential drugs at appropriate levels of the public health system. However progress has been slow in ensuring access and in many states medicines are not available through the public health system when they are required. There are several reasons why this is the case. The first reason is lack of adequate supplies due to constraints of funding and of procurement policies. The second reason is the poor functioning and outreach of public facilities (which we have discussed in earlier chapters).

Prime Minister Manmohan Singh, a few months back, had announced a "free medicines" scheme, under which all essential medicines would be available free of cost in all public facilities. JSA welcomes this scheme but is also concerned that there have been mixed signals from the Government since then. While initially the Government had said that the 'free medicines' scheme would be a central scheme with support from central funds, subsequently there appears to be a shift to saying that the health ministry will encourage state governments to launch such schemes. JSA considers this a betrayal of the earlier promise and strongly recommends that the central government allocate 5,000-6,000 crores every year, which it had earlier proposed, to make this scheme operational in all parts of the country. It may be noted that such a scheme (free medicines for all) has been operational in some states for a long time (viz. Tamilnadu). These experiences need to be adopted in others states, especially that of the Tamilnadu Medical Services Corporation (TNMSC) in developing transparent norms for drug procurement and distribution for public sector facilities. TNMSC procures only essential medicines in generic names, directly from manufacturers. This practice reduces waste of resources on procurement of costly branded drugs and on irrational formulations. TNMSC has also developed a computerized net work for distribution and has developed a mechanism for quality testing.

Also important to note is the recent initiative in Rajasthan to implement a free drug scheme (now one year old). Early reports regarding this scheme are very encouraging and there is evidence that utilization of public facilities have increased significantly since the launch of the scheme. There are very recent disturbing reports that there are attempts to dilure the initiative, at the behest of a section of the medical establishment.

Features of the TNMSC model

It should be noted that success of TNMSC is due to seceral crucial features, such as:

- **Full autonomy** – Once broader policy has been decided, no reference is made to the government; all decisions are taken by the board.
- **Transparency-** Name of medicine, price of purchase, name of manufacturer and report of quality testing etc. are posted on website to bring transparency in the system.
- **Demand responsive system-** Each PHC can choose the medicines and their quantity as per need within the budget of Rs. 1.2 lac by using a 'passbook' (instead of conventional indenting).
- **Updated and limited list of essential medicine-** TNMSC procures medicines from a limited list of medicines (260 Essential Medicines and 200 other 'Speciality Medicine' (compared to a big list of 1800 medicines in Maharashtra).

Source: Drug procurement policy and procedure, TNMSC, Tamil Nadu Medical Services Corporation Limited.

A hallmark of free drug availability in public facilities has to be procurement and prescription in generic names. As we shall see later, drug companies are able to charge very high costs by promoting their Brands, while generic drugs sold in generic and not brand names are much cheaper – at times they may cost 10% or less of the cost of branded drugs. JSA strongly supports the move to ensure that all doctors in all public facilities prescribe drugs in generic names only. This will have to be accompanied by matching measures that ensure availability of all essential drugs in generic names in public facilities.

Rational Use of Medicines

An Essential Drugs Policy is a prerequisite for ensuring that physicians prescribe medicines based on sound scientific evidence. An ideal situation would be one where the only medicines that are available for prescribing, are those that are scientifically validated and are recommended in standard text books that students read in medical college. Unfortunately the real

situation is very different, and students fresh out of college are suddenly confronted with a plethora of medicines that they have read little or nothing about. This happens because of the mismatch between rational treatment goals and the goals of commerce that are pursued by drug manufacturers. Drug manufacturers are driven by the need to maximise profits, not by the need to optimise therapeutic goals.

In India, an average family spends Rs.3,000 every year in buying medicines and on diagnostic investigations. It has been **estimated that at least 50% of this expenditure is incurred on irrational or unnecessary drugs and diagnostic tests**. This adds up to a colossal waste of Rs.30,000 - 40,000 crores every year, and amounts to an average unnecessary drain of Rs.1,500 per year for every family. The first, and best known, part of irrational practices in health care is related to irrational prescription of drugs. WHO has defined irrational prescribing as use of a therapeutic agent when the expected benefit is negligible or nil or when its usage is not worth the potential harm or the cost.

Irrational drug prescribing can occur when the medication prescribed is incorrect, inappropriate, excessive, unnecessary or inadequate. All these irrational practices are rampant in India. The reasons are manifold. One is to do with the proliferation of a large number of drugs in the Indian market that are either irrational or useless. With rapid developments in Science and Technology there has been an explosion in the number of drugs which are available in the market. Unfortunately only a small minority of drugs entering the market offer an advantage over existing drugs. A study by the French journal, Prescrire International, estimated that out of 2257 medicines introduced in the global market between 1981 and 2000, 0.31% were a major therapeutic innovation and 2.96% were an "important" therapeutic innovation, while 63.23% "does not add to existing clinical possibilities". The situation in India is no different and probably worse, given the fact that our Drug Control mechanisms are much more lax than in developed countries. The only reason why Indian studies are not available is because there is virtually no mechanism in India to monitor the use of irrational and hazardous drugs.

There are an estimated 60,000 to 80,000 brands of various drugs available in the Indian market. On the other hand the essential drug list in India contains just 348 drugs. In this situation of extreme anarchy the task of an already overstretched

Drug Control Authority becomes almost impossible to cope with. A majority of the estimated 80,000 products in the market are either hazardous, or irrational or useless.

The pharmaceutical companies and the government regulatory bodies – prominently the Central Drug Standards Control Organisation (CDSCO) — need to share the blame for allowing such a situation to develop. **The 59th Report of the Parliamentary Standing Committee of Health and Family Welfare has extensively documented the fraudulent role of the CDSCO**. The Committee examined approval of 42 new medicines and found that, in the case of 33 of these medicines, there existed no scientific evidence to show that these are really effective and safe in Indian patients. No trial was conducted for 11 medicines. When trials were conducted, they were of dubious nature. The report documents clear evidence of doctors providing 'expert' opinion of a dubious nature in collusion with medicine companies. Evidence was found that in the case of two medicines approval was granted by non medical staff. It may be noted that the Committee studies only a small sample of the total number of drug approvals. It is evident that the practices documented in the committee's report pervade the entire drug approval process in the country.

All this would not be possible without the **active involvement of the medical profession, who contribute by prescribing such irrational and useless drugs**. One reason for this is the fact that there is almost no source of regular unbiased, authentic information on drugs available in the country. Given the rapid changes in treatment procedures and introduction of a large array of new drugs, medical practitioners need to update their knowledge regularly. Such a system of continuing medical education is largely absent in this country, and most doctors do not find the need to take time out from their busy practice to update their knowledge by reading the most recent books and journals. Thus we have the sad practice of a bulk of medical practitioners depending on promotional material supplied by Pharmaceutical companies. Obviously such promotional material only provides information to doctors, with a view to maximising the sale of the products being promoted. There is documented evidence that many of the claims in the promotional material are false or exaggerated. It thus makes it possible to sell a large number of useless and irrational drugs.

The problem is not limited to just a question of irrational or useless or harmful drugs. Rational, or even life saving drugs

can be used in an irrational manner. The commonest problem is the unnecessary use of drugs. Thus, often we see expensive antibiotics being used for trivial infections. Moreover this is often accompanied by wrong dosage schedules. Another problem is the prescription of a large number of drugs for a simple ailment, when one or few drugs would have sufficed. Doctors, in many cases, when they are not sure of the diagnosis prescribe a large no. of drugs to cover for all the possibilities. Thus a patient coming with fever may be given some antibiotic, a drug to treat malaria, a drug to treat typhoid, etc. It may turn out that the patient was just suffering from a viral fever, which could have been treated with a few paracetamol tablets, only. Such prescription practices increase the cost to the patient, unnecessarily exposes the patient to potential side effects, and in the case of antibiotics leads to drug resistance, i.e. a situation when these antibiotics become useless when they are really required. Resistance to commonly prescribed antibiotics is becoming a major problem in India. In the case of Tuberculosis and malaria, it has led to emergence of strains that are resistant to the cheaper drugs that were earlier used. ***Drug resistant to first line TB drugs has lead to India having the largest number of MDR (multi drug resistant) TB cases in the world.*** MDR cases need treatment with second line drugs that can be 10 times more expensive than first line drugs. MDR TB cases also have a much higher rate of death even when treated.

While the costs of individual drugs is very important, what affects patients is the total cost of treatment. Irrational drug use increases treatment costs, at times enormously, by promoting use of drugs when they are not indicated. At the heart of the problem is the license provided by drug regulatory agencies to produce hundreds of combination products (which combine two or more drugs). As a first step, the ***JSA recommends, all except a few scientifically valid (20 or less) combination drugs be banned.***

Promotion of Medicines by Companies

Companies spend large amounts to promote medicines, and this is particularly so when they need to promote medicines that are irrational and their use is contrary to scientific evidence. Effective medicines have an obvious marketability and demands are self-generating. But any drug that is therapeutically not valid needs artificial generation of demands and contributes to un-

Table 4: Change in Overall Price Control Parameters			
DPCO Year	No. of Drugs under Price Control	Percent of market under Price control (approx.)	Mark-up (profitbility (allowed)
1979	347	80-90%	40%, 50% and 100% in three categories termed "life saving", "essential" and "non essential"
1987	142	60-70%	75% and 100% in two categories
1995	74	25-30%	100% (one category)

ethical marketing practices. Irrational prescribing practices are often initiated and maintained by marketing techniques of the drug industry. ***The industry spends 20% of its annual sale or about Rs. 3,000 crores in advertising; this works out to about Rs. 50,000 per doctor per annum and each doctor prescribes drugs worth Rs. 250,000 per annum.***

Drug companies have been known to use incomplete or misleading evidence to promote irrational medicines. Physicians are sought to be influenced by a variety of inducements and sponsorships. Such a practice gets perpetuated also because prescribers depend on information provided by drug companies, as there is scant availability of unbiased information on the rational use of medicines.

There is **no effective law that prevents drug companies from bribing doctors** to prescribe their medicines. In the face of sustained criticism regarding the massive amounts of money spent by companies to induce doctors, the Govt. came out with a draft code of ethics for marketing of medicines in June, 2011. The code is supposed to be voluntary, which means that a violation of the code does not warrant any punishment. The Government's failure to bring in a code of marketing that is effective and enforceable can only be viewed as a deliberate ploy to allowing drug companies to continue to influence doctors through unethical means.

Pricing of Medicines

There is also evidence that costs of medicines constitute a major proportion of total health care costs. The NSS (National Sample Survey) 55th round (2000) on consumer expenditure shows that 77% of health expenses in rural areas and 70% in urban areas is on medicines alone. The NSS morbidity survey of 2004 (Report no 507), showed that medicines account for 81% of health care expenditure in rural areas and 75% in urban areas (all India 79%).

A prominent feature of the medicines market in India is that a very large proportion of drugs consumed in India are procured through retail sales – an estimated 80-85%. Institutional sales which account for 15% of the market include consumption through the public sector as well as through private hospitals and other institutions. This is very different from what is seen in developed country markets, where a bulk of drug consumption is through supplies from large institutional mechanisms (hospitals, health insurance, etc. both in the public and private sector).

Since 1970, the Government has endeavoured to regulate the prices of some drugs through successive Drug Price Control Orders (DPCO). It must be understood that the DPCO regulates the prices of only a fraction of the drugs in the market, and those drugs whose prices are controlled are notified in the relevant DPCO. In the case of all other drugs, the prices are not controlled and companies are at a liberty to charge whatever they wish.

Over the last three decades, successive Drug Policies have specified different norms to exercise control on drug prices. The number of drugs under Price Control have come down from 342 in the DPCO 0f 1979 to 74 drugs in the DPCO of 1995 (which is still under operation).

Due to the almost total decontrol of drug prices, over-pricing is rampant in the country. A study commissioned by the National Commission on Macroeconomics and Health showed that there is a very wide variation in the prices of drugs sold in retail and those sold in bulk through tenders to institutions. The price differences ranged from around 100% to 5600%.

There is also a wide variance in prices of the same medicine sold under different brands by different companies Moreover, the more expensive brands sell much more than the less expensive ones because companies are able to promote their

expensive brands by offering incentives to doctors and chemists.

Recently the Group of Ministers (headed by Sri Sharad Pawar), tasked to decide on the modalities of drug price control, has recommend a 'market based' mechanism to control drug prices of all essential drugs. This goes entirely against the grain of the *Supreme Court's directive* to the Government to expeditiously put in place a mechanism to control the prices of all essential drugs so that prices of medicines can become affordable. The Supreme Court had responded to a PIL filed by the All India Drug Action Network (AIDAN) which had argues that drug prices in India are a major cause for *catastrophic medical expenses* and that they need to be brought under control.

The Government is now set to introduce the concept of 'Weighted Average Price' (WAP) as the method for fixing the ceiling price of drugs. In such a system the present prices of existing brands and their respective share in the entire market of a particular drug will be taken into account to compute the ceiling price. Such a method is entirely skewed, as the ceiling price fixed would largely reflect the price of the brand leaders. Generally 2-3 top selling brands – usually the most expensive or some of the more expensive brands — control a bulk of the market. So price control will do nothing to bring down drug prices, and in fact will encourage cheaper brands to start charging more and approach the high ceiling price. This would only *legitimize the rampant over-pricing of drugs by companies,* prevalent today.

Since the prices of medicines in the bulk market and the costs for manufacturing formulations are widely known *there is no difficulty in fixing prices based on a cost based formula.* Currently as per the 1995 Drug Price Control Order, the post manufacturing expense (MAPE) allowed is 100% and includes the profit for the company. The JSA demands that the *Government should heed the Supreme Court's directive* and control the prices of all 348 essential drugs by continuing to use the cost plus formula of price fixation – where the price of a drug is calculated based on the raw material and manufacturing costs, after allowing for a fair profit margin.

Even if *the 'Free Medicines' scheme,* which is meant to provide essential medicines free of cost to all those who visit public health facilities, is expeditiously implemented in the country, the need to regulate medicine prices would continue. Currently even in a more developed state like Maharashtra only 12 -15 percent of patients visit PHFs. In Tamil Nadu, which provides free medi-

cines in the public sector from 1995, not more than 40% of patients visit the public sector.

Drug Policy Formulation in India

Drug policies in India are formulated by the Ministry of Chemicals and Fertilizers. In addition, in 1997, the National Pharmaceutical Pricing Authority (NPPA) was instituted as an independent body to monitor drug prices and to take decisions on pricing. The Ministry of Health and Family Welfare looks into the issues of quality, manufacturing, sales and distribution of drugs. These two functions are performed in isolation and there is minimal co-ordination between the two major areas of policy making in the pharmaceutical sector.

As a result the drug policy focuses only in the areas of production and pricing. Drug policies, thus formulated, have not incorporated a focus on health. In successive policies, the emphasis has shifted to addressing the viability of the private pharmaceutical industry. In the absence of a coherent link between health needs and the policies on drug pricing, issues of equity have been generally ignored.

There is thus, the need to formulate a National Pharmaceutical Policy that addresses the critical issue of universal access to essential medicines. Such a policy needs also to harmonise laws and regulations covering different aspects of the Drugs and Cosmetics Act and the Magic Remedies Act.

The Govt. had prepared a draft 'Pharmaceutical Policy-2006 (Part-I)' which is yet to be finalized. The second part of the policy, related to pricing, has been kept pending for over 6 years by the Group of Ministers set up under the chairmanship of Sri Sharad Pawar. We have discussed, above, the chaos such delay has created in the area of drug pricing. It is urgent and necessary that a comprehensive policy be prepared by an inter-sectoral committee of the Ministry of Health & Family Welfare and Ministry of Chemicals & Fertilizers after discussions with all sections that have a stake in the pharmaceutical sector. The two should jointly constitute a National Drugs and Therapeutic Authority, which should be a statutory body with powers to regulate all aspects of the National Pharmaceutical Policy.

Changing Policy environment and Impact on Pharmaceutical Industry

India can take credit for the first major initiative in a developing country to attempt to achieve self reliance in the area of medicines manufacture. It is possible to identify three major reasons why this was made possible.

Table 5: Acquisition of Indian Drug Companies

Year	Indian Co.	Foreign Company which took over	Take-over amount (US$ million)
2006	Matrix Lab	Mylan Inc. (USA)	736
2008	Dabur*	Fresenius Kabi (Singapore)	219
2008	Ranbaxy	Daiichi Sankyo (Japan)	4600
2008	Shanta Biotech	Sanofi Aventis (France)	783
2009	Orchid	Hospira US	400
2010	Piramal	Abbot (US)	3720

* One Diivision

The first relates to the Indian Patents Act of 1970. The Act superseded the colonial Act of 1911 and allowed Indian companies to produce drugs in India that were patented by foreign companies. In a decade the effects were clearly visible and India came to be known as the "pharmacy of the South". Indian companies were able to produce patented medicines, within 2-3 years of their being introduced into the global market, and that too at one-tenth to one-hundredth of the price at which the patented drugs were being marketed. Thus a huge dent could be made in the monopoly enjoyed by European and American pharmaceutical companies.

The second relates to initiation of manufacture of drugs from the basic stage by Indian public sector companies. Hindustan Antibiotics Limited (HAL) and Indian Drugs and Pharmaceuticals Limited (IDPL) were responsible for starting drug production in India in the late 1950s and early 1960s. It was the pioneering effort by Indian scientists and technologists in these two public sector companies that forced Foreign companies to also start production in India and paved the way for a slew of private Indian companies to follow suit.

The third reason was the implementation of the recommendations of the Parliamentary Committee on Drugs and Pharmaceuticals (known as the Hathi Committee), through the Drug Policy of 1978. The 1978 Drug Policy imposed several restrictions on the operations of foreign companies and provided preferential treatment to Indian companies – both in the public sector and the private sector. The result of these measures was dramatic – the share of the Indian market enjoyed by Multinational Corporation fell from over 75% to less than 25% within a span of a decade.

Unfortunately, all these three initiatives have been reversed in the last two decades. HAL and IDPL were systematically undermined as a result of inept management and withdrawal of preferential treatment. The 1978 policy's major thrusts were diluted and reversed in successive policies in 1986, 1994 and 2002. And finally, the 1970 Patent Act was amended in 2005, because of India's annexation to the World Trade Organisation (WTO) in 1995 which compelled it to sign the Agreements on Trade Related Intellectual Property Rights (TRIPS). As a result, Indian companies have lost the right to produce medicines whose patents are held by foreign multinationals.

The drug industry has seen a distortion in the pattern of drug production. In the absence of a clear cut policy to ensure and channelise production of essential drugs, a major share of the production is being diverted into non essential areas. This has led to a huge rise in production of irrational and useless medicines (estimated to be at least 50% of the total drug consumption in the country) – supported by unethical promotion by drug companies and an unholy nexus between a section of the medical profession, chemists and drug manufacturers.

Possibly the most disturbing trend in the drug industry is that de-industrialisation has increased at a frightening pace and many companies are dependant on imported bulk drugs. Over the years many large companies have cut down Bulk Drug production (i.e. drugs produced from the basic stage) and are increasingly acting as mere traders. In many therapeutic groups, major production is accounted for by the Small Scale sector.

The unraveling of the Indian industry in the post liberalisation phase is now being played out. Many large Indian private sector companies, having embraced the notion of a strong Patent regime, see their future in tie-ups with MNCs. The ball was set rolling by the Ranbaxy – Glaxo Smith Kline tie up. This was sub-

sequently followed by the takeover of Ranbaxy (then the largest Indian company) by a Japanese company – Daichi.

There is also a clear move towards acquisition of major Indian companies by foreign multinationals (Table below).

Takeover by multinationals of Indian companies will further orient them away from the Indian market, thus reducing domestic availability of the drugs being produced by them. The reversal of trends in the drug market is evident from the fact that of the 10 largest drug companies in India in 1998-99, only one (Glaxo Smith Kline) was a foreign company. Today three of the top ten companies are foreign owned (Ranbaxy, Glaxo Smith Kline and Piramal).

It is unfortunate that based on a poorly researched report by the Planning Commission the Indian Government has chosen not to act on these concerns. JSA believes that it is necessary to reverse the policy of allowing 100% FDI in the pharma sector through an automatic route.

Patent Rights and access to medicines

The change in the Indian Patent Act in 2005 took away a valuable tool available with Indian companies. It is worth noting that the health safeguards in the 2005 amendments to India's patent laws are being used to an extent to ensure continued access to new drugs. The JSA stands in solidarity with several activist organizations – positive peoples networks, Lawyers' Collective, Medecins sans Frontieres, Cancer Patients Association, and many others — that have fought legal batties and mobilized on the streets to ensure use of the safeguards. There have been several positive judgments pronounced recently that have made use of the health safeguards in the Indian law. These include the issuing of the first compulsory license (i.e. a license to an Indian company to produce a patented drug manufactured by a foreign company) for an anticancer drug (sorafenib) and reversal of the first drug patent since 2005 that had been issued for a drug for Hepatitis-C (peginterferon).

In spite of these victories many new drugs are now being granted patents and are way out of the reach of almost all Indians. Multinational corporations continue to try to challenge the positive parts of the Indian law – the Swiss company, Novartis, is still continuing its challenge to a key portion of India's law in the Supreme Court.

Several areas of concern remain and we underline some of the key demands:

- Public health safeguards such as the use of compulsory license should be used liberally to safeguard public health, instead of being considered as the "last resort"
- No TRIPS Plus measures to further strengthen IP protection, viz. in the form of data exclusivity, patent linkage, patent extension etc. should be allowed – either as autonomous measures or through Free Trade Agreements
- The Government needs to defend its own Patent law and resolutely fight the legal challenges being mounted by MNCs
- The Drug Registration mechanism should not be allowed to act as the Patent "police" safeguarding interests of private companies
- The Government should establish an institutional mechanism to monitor the impact of patented medicine on access to medicine and recommend suitable measures to ensure access.
- Patent office should take steps to ensure transparency in its process of granting and maintenance of patents. Further, the patent office should impose strict guidelines on the patent applicant to facilitate the disclosure of invention as well as the international non-proprietary names (INN) of the pharmaceutical substance.

Unethical Clinical Trials

India has become the preferred destination for conducting clinical trials, a large number of them by MNCs through Contract Research organizations (CROs). The Government has encouraged this by changing the Drugs and Cosmetics Act in 2005. There is extensive evidence that regulatory measures are being circumvented in the conduct of many such trials. Many of these trials also target women, especially poor women who are vulnerable. The JSA demands that the regulatory mechanism on clinical trials be strengthened and all clinical trials be monitored by an authority with statutory powers.

Building a movement to mobilise for Health and Health Care for All

The transformations that we seek, in order to ensure Health and Health care for all, must be based on developing a broad socio-political movement. As we seek to develop such a movement, we need to keep in mind certain major tasks and challenges.

The dominant socio-political framework today is strongly influenced by the neoliberal 'market friendly' ideology which places growth of the corporate private sector — including the corporate hospital sector, pharmaceutical and insurance industries — above the real health needs of the people. This is exemplified by the Planning Commission's chapter on Health (various drafts have been in circulation) for the 12th Five year plan. We will **need to strongly challenge and oppose this dominant framework, which manifests in various forms of privatisation and corporate friendly programmes** and schemes, some of which have been described in this booklet. In the coming period, we are likely to see major struggles between 'profit logic' and 'social logic' in the health sector. Defending and promoting 'social logic' and rolling back 'profit logic' in the health sector will require building broad based alliances, not only of health activists and health professionals, but also mass organisations, trade unions, political parties and representatives, and various progressive forces.

While this booklet has focussed on certain aspects of Health care, it is obvious that moving towards 'Health for all' requires **major transformations not only in the area of Health care, but also in a wide range of social determinants of health** – food security and nutrition, water supply, sanitation, working conditions, housing, environment, education and other sectors. The same kind of challenges that afflict the health system – of a dominant private sector and neoliberal, market friendly policies, combined with weak public systems – plague most of these allied sectors. Hence working on these fronts requires building alliances with like-minded campaigns, such as the campaign on Right to food and campaigns against privatisation of water, towards building a broad people's movement in the social sector which challenges privatisation and corporate friendly 'public-private partnerships'.

This booklet examines how, besides direct privatisation of public health services, a wide variety of 'Public private partnerships' (PPPs) are now being institutionalised across the coun-

try. These are being justified on the basis that they would make services available to people, especially the poor. We need to take an extremely critical look at such models, since most of them place public resources in private hands without making the involved private providers follow a public logic, and without the public interest being promoted in a larger sense. Besides piecemeal and local or state specific 'PPPs', we are now seeing the emergence of proposals for 'Managed care' and 'Corporatisation of public health facilities' at the national level. This threatens to elevate the promotion of profit logic in the health sector to a qualitatively higher level.

We also need to be aware that **diametrically opposing conceptions of 'Universal health care' are contending today at global and national levels**. On one hand, the concept of 'Universal health coverage' is being promoted by certain international agencies, and seems to have been **taken up by the Planning commission in India, in a *framework that uncritically endorses and promotes the existing private medical sector*, including its high costs and irrationality**. This framework advocates handing over public funds, often through the insurance route, to the private sector to expand 'coverage'. This **needs to be countered by the alternative *vision of Health care for all in the larger framework of 'Health for all', which envisages a transformation of the health system in a setting of broader social transformations*.** This vision dates from the Alma Ata declaration of 1978, and certain aspects of this approach dealing with aspects related to 'Health care for all' in the current context have been outlined in this booklet. Health activists need to be keenly aware of the crucial differences between these opposed conceptions — between 'UHC Pvt. Ltd.' and 'Health and Health care for all' — which might sometimes superficially appear to have similar objectives.

We also need to recognise that while we oppose privatisation and champion public systems, there is a **need to 'reclaim' public systems while they are strengthened and expanded**. There is a growing recognition that public systems need to be made accountable with active involvement of people at various levels; a range of initiatives ranging from demanding Right to information, to whistle-blowing against corruption, to conducting Social audits and Community based monitoring, exemplify the social churning that is underway to redefine the relationship between public systems and the public. Unions and associations of health care workers are increasingly opposing privatisation, semi-privatisation and contractualisation in vari-

ous forms, and hence would be crucial allies for the health movement in the coming period.

Finally, based on not only the analyses in this booklet but the broader range of experience of the health movement, we can confidently say that '**there are alternatives!**'. On one hand, neoliberal policies stand increasingly exposed across the globe, as evident from the multiple crisis facing the globe – financial, food and environmental — and the massive growth of inequities within countries and between countries. On the other hand, in diverse contexts people are forging alliances, are engaging with public systems in new ways, and are developing alternative models in a manner that generates hope and optimism. While we have an uphill struggle ahead of us, there is no doubt that widening sections of people are questioning the existing manner of functioning of the health system, and are beginning to expect qualitatively better ways of organising health care. Hence the **health movement needs to take up the challenge of building broad based alliances** with other social movements, to challenge corporate oriented health care models, and to instead place a public-centred system of 'Health care for all' squarely on the social agenda, as a key step towards achieving the dream of 'Health for all'.

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Jan Awasthya Abhiyan (JSA) is a Network of several all India networks and regional and state level networks that work to promote health and acccess to health care. The National Co-ordination Committee of JSA includes the following organisations:

- All India People's Science Network (AIPSN)
- All India Drug Action Network (AIDAN)
- Asian Community Health Action Network (ACHAN)
- All India Democratic Women's Association (AIDWA)
- Bharat Gyan Vigyan Samiti (BGVS)
- Breast Feeding Promotion Network in India (BPNI)
- Catholic Health Association of India (CHAI)
- Centre for Community Health and Social Medicine, JNU
- Christian Medical Association of India (CMAI)
- Forum for Creche and Child Care Services (FORCES)
- Fed. of Medical Representative Assns. of India (FMRAI)
- Joint Women's Programme (JWP)
- Medico Friends Circle (MFC)
- National Alliance of People's Movements (NAPM)
- National Federation of Indian Women (NFIW)
- National Association of Women's Organisations (NAWO)
- Positive Women's Network
- PRAYAS (Rajasthan)
- SAHYOG
- SAMA – Resource Group on Women's Health
- SATHI – CEHAT
- Society for Community Health, Awareness, Research and Action (SOCHARA)
- Voluntary Health Association of India (VHAI)

In addition state JSA organisations, representing a large number of state level organisations working in the area of health and health care are members of JSA's National co-ordination committee.

Jan Swasthya Abhiyan
National Secretariat:

c/o Delhi Science Forum, D-158, Lower Ground Floor, Saket,
New Delhi 110017. Ph: (011) 26524323/24
Email: jsasect.delhi@gmail.com

c/o SAMA, B-45, 2nd Floor, Main Road Shivalik,
Malyiva Nagar, New Delhi 110017.
Ph: (011) 65637632/26692730